DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11043 (Rev. 06/03)

WISCONSIN MEDICAID
RESPIRATORY CARE SERVICES / PLAN OF CARE (RCS/POC)

Instructions: Type or print clearly. Before completing this form, read the Respiratory Care Services/Plan of Care (RCS/POC) Completion Instructions (HCF 11043A).

SECTION I — RECIPIENT / PROVIDER INFORMATION

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Provider	**Wisconsin Medicaid Provider Number**

SECTION II — RESPIRATORY CARE SERVICES REQUIRED

Service (Airway Management) (check if applicable)	**Frequency**	**Comments**
❑ Stoma	Times per 24-hour period	
❑ Tube change	Times per month	
❑ Suctioning — Nasal	Times per 24-hour period	
❑ Suctioning — Tracheal	Times per 24-hour period	
❑ Suctioning — Oral / Pharyngeal	Times per 24-hour period	
❑ Airway humidification used with ventilator 1.	Hours per 24-hour period	
2.		
❑ Airway humidification used if off ventilator 1.	Hours per 24-hour period	
2.		
❑ Supplemental oxygen		

List scope of at least three parameters to be monitored for recipient (e.g., vital signs, breath sounds, secretions)	**Times per 24-hour period parameter assessment completed**	**Comments**
1.		
2.		
3.		
4.		
5.		
6.		

Continued

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Provider	Wisconsin Medicaid Provider Number

SECTION II — RESPIRATORY CARE SERVICES REQUIRED (Continued)

Service (Ventilatory Support) (check if applicable)	Frequency	Comments
❑ Ventilatory support — Positive pressure	Hours per 24-hour period	
❑ Ventilatory support — Negative pressure (e.g., poncho)	Hours per 24-hour period	
❑ Other (list type)	List frequency	
❑ Monitoring ventilator (list at least two parameters below) 1.	Hours per 24-hour period	
2.		
3.		
4.		
❑ Ventilator maintenance (list at least one parameter below) 1.	Times per week	
2.		
3.		
4.		

SECTION III — EMERGENCY PLAN

Is an emergency plan written and available? ❑ Yes ❑ No

Is airway management disruption (e.g., decannulation) life threatening for recipient? ❑ Yes ❑ No

List specific events (if any) to which this recipient is susceptible (e.g., severe bronchospasm).

1.

2.

3.

4.

Emergency plan available for following areas?	Yes	No	Comments
Airway management	☐	☐	
Disaster plan (e.g., for tornado or fire)	☐	☐	
Hospitalization	☐	☐	
Hypoxic events	☐	☐	
Oxygen supply depletion	☐	☐	
Resuscitation	☐	☐	
Respiratory compromise	☐	☐	
Ventilatory equipment failure	☐	☐	
Transportation	☐	☐	
Other (list below)	☐	☐	

Continued

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SECTION III — EMERGENCY PLAN (Continued)

List back-up equipment available (list at least two resources [e.g., emergency equipment or power sources] below).

1.

2.

3.

4.

Arrangement for emergency / acute care? ❑ Yes ❑ No

Comments

Recipient requires monitoring devices? ❑ Yes (list below) ❑ No

Device	Frequency	Comments
1.		
2.		
3.		
4.		

Recipient requires adjunctive techniques (e.g., chest physiotherapy, aerosolized meds)? ❑ Yes (list below) ❑ No

Type	Frequency	Comments
1.		
2.		
3.		
4.		

SECTION IV — FUTURE AND OTHER CARES

Recipient is expected to be weaned from ventilator? ❑ Yes ❑ No

Identify time period from today's date when weaning program would begin. _____ Weeks _____ Months

Is there a written plan for weaning program available? ❑ Yes ❑ No

Recipient is receiving other services? ❑ Yes (check applicable services below) ❑ No

- ❑ Dental
- ❑ Disposable Medical Supplies
- ❑ Drugs
- ❑ Durable Medical Equipment
- ❑ Educational
- ❑ Nutritional
- ❑ Occupational Therapy
- ❑ Physical Therapy
- ❑ Physician (specialty)
- ❑ Psychotherapy
- ❑ Respiratory Therapy
- ❑ Social
- ❑ Speech Therapy
- ❑ Vocational
- ❑ Other (list): _____

Continued

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SECTION V — CASE COORDINATION

Plan is in place for coordination of services?	❑ Yes	❑ No
Case coordinator has been designated?	❑ Yes	❑ No
I am the case coordinator.	❑ Yes	❑ No (name of case coordinator) _

Describe other pertinent respiratory care needs below.

List any other comments below.

SIGNATURE — Nurse	Position Title	Date Signed
SIGNATURE — Physician	Position Title	Date Signed

Reset Form